DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/01/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	(AZ) MI			COMPLETED	
AND PLAN	OF CORRECTION		A. BUII	LDING	00		
		150164	B. WIN			07	/11/2011
NAME OF D	ROVIDER OR SUPPLIEF		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	KOVIDEK OK SOTT EIEF			4011 S	MONROE MEDICAL PARK	BLVC	
MONROE HOSPITAL				BLOOM	/INGTON, IN47403		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT	ON	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO) BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
S0000			İ				
	This visit was fo	or the investigation of a	S0	000	No citation attached.		
		ospital complaint.					
		ospitar compianit.					
	Complaint Numl	her:					
	•	oci.					
	IN00091425						
	TT 1	D. C					
		: Deficiencies unrelated					
	to the allegation	are cited.					
	Date: July 11, 2	011					
	Facility: 004287						
	Surveyor:						
	Billie Jo Fritch F	RN. BSN. MBA					
	Public Health N						
	i uone meann m	uise suiveyoi					
	QA: claughlin 0	08/16/11					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150164	(X2) MU A. BUILI B. WING	DING	nstruction 00	(X3) DATE SURVEY COMPLETED 07/11/2011		
NAME OF PROVIDER OR SUPPLIER MONROE HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 4011 S MONROE MEDICAL PARK BLVC BLOOMINGTON, IN47403					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE	
S0762	to, the following: (13) A discharge sauthenticated by the final progress note for the discharge so of a normal newbouncomplicated obstinal progress note instruction given to family. Based on document the hospital failed completion of modays for 2 of 5 m (MR#2, MR#4) the summary or final findings include 1. Review of part 7-11-11 indicated MR#2 was admit discharged 5-10-a discharge summanote. MR#4 was admit discharged 4-23-a discharge summanote. 2. Review of the sauthenticated of the sauthenticated summanote.	ords, except ns (g), shall ntain, but not be limited fummary the physician. A e may be substituted fummary in the case orn infant and stetric delivery. The e should include any to the patient and ent review and interview, d to ensure the edical records within 30 fiedical records reviewed that lacked a discharge I progress note. itient medical records on d the following: tted on 5-8-11, 11 and the record lacked mary or final progress	SO	762	The Director of H.I.M and the Medical Staff Liason office ha implemented new monitors a messages to the medical star deliquent records. They have issued letters according to the facility by-laws on suspension becoming automatic on the 3 day if a record has not been completed at the 30 day mar Director of H.I.M. is monitoring the issue daily and reporting monthly performance improvement deliquency rate the Director of Quality.	as nd ff on e e e ns i1st kThe ng new	08/01/2011	

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		LDING	ONSTRUCTION 00	(X3) DATE COMPI 07/11/2	LETED
	PROVIDER OR SUPPLIE	R	4011 S	ADDRESS, CITY, STATE, ZIP CODE MONROE MEDICAL PARK B	_VC	
MONROE HOSPITAL			BLOOM	IINGTON, IN47403		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL					(X5) COMPLETION
PREFIX TAG	the following: F. A discharge or dictated on prover forty-eight progress note madischarge summer who required less hospitalization. G. All members completing their thirty (30) days Failure to compate the suspension of the susp	summary shall be written atient hospitalizations (48) hours. A final ay be substituted for the tary only for those patients are responsible for remedical records within of a patient's discharge. In the grand delinquent and the grand admitting, and consults, etc. th #S3 on 7-11-11 at 1255 the medical records of the Hack discharge and progress notes; delinquent and has not per medical staff rules equirements. th #S5 on 7-11-11 at 1315 the medical records of the Hack discharge and progress notes. th #S4 on 7-11-11 at 1405 the medical records of the Hack discharge and progress notes. th #S4 on 7-11-11 at 1405 the medical records and has not per the medical staff rules	PREFIX TAG	CROSS-REFERÊNCED TO THE APPROPRIED TO THE APPROP		DATE

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
		150164	B. WIN	G		07/11/2	011
NAME OF PROVIDER OR SUPPLIER MONROE HOSPITAL			•	4011 S	NDDRESS, CITY, STATE, ZIP CODE MONROE MEDICAL PARK BLV IINGTON, IN47403	C	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
S0870	410 IAC 15-1.5-5(b	b)(3)(N)					
50870	(b) The medical statenforce bylaws and its responsibilities. and rules shall: (3) include, but not the following: (N) A requirement orders shall be: (i) in writing or according and medical staff p. Based on document the medical staff medical staff rule to authentication signature and dat 5) medical record.	aff shall adopt and d rules to carry out These bylaws It be limited to, that all physician ceptable computerized inticated by the responsible dance with hospital colicies. Cent review and interview, failed to enforce the es and regulations related requirements to include the for 4 of 5 (MR#1, 2, 3, and s reviewed.	S0	S0870 The form in question "Do Not Resuscitate" physician order sheet has been changed to include a signature block, date and time slot for physicians. The Case Manager has begun reviewing all physician orders on a daily basis for proper documentation and authentication as outlined in hospital policy. The Director of H.I.M has created a		09/01/2011	
	7-11-11 indicated	medical records on the following: MR#1, 2, ate with the physician			new performance improvement measure to report improper authentication on physician orders to the Director of		
		orinted orders titled			Performance Improvement a	nd	
		otocol: Physician Order			the Medical Staff liason office) -	
	Sheet.				where the daily offenses will		
		rds (MR#1) lacked the			sent to the physician immedi	ately.	
		are on the preprinted					
		uscitation Protocol:					
	Physician Order S						
	2. Review of the						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

F6RI11

Facility ID:

004287

If continuation sheet

Page 4 of 7

		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UNDERSO 00			(X3) DATE SURVEY COMPLETED	
		150164	A. BUILDII B. WING	NG		07/11/2011		
NAME OF PROVIDER OR SUPPLIER MONROE HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 4011 S MONROE MEDICAL PARK BLVC BLOOMINGTON, IN47403					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		PRI	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY.			(X5) COMPLETION	
S0872	Bylaws/Rules and 7-11-11, approve the following: C Preprinted orders included as a part dated and signed 3. Interview with hours confirms the resusitation proto death"; #S5 confirms of MR#1, 2, 3, and A-N-D (allow not signed by the phyphysician signatus staff rules and regular to the following: (b) The medical state enforce bylaws and its responsibilities, and rules shall: (3) include, but not the following: (P) A requirement diagnosis be document completion of the rewithin thirty (30) day discharge. Based on document medical staff failed to the following:	d August 2009, indicated . 2. Preprinted Orders: s of members shall be t of the medical record, by the member. n #S5 on 7-11-11 at 1315 nat A-N-D is the local to "allow natural firms the medical records and 5 lack a date when the tural death) orders were lysician and MR#1 lacks a lare as required by medical gulations. b)(3)(P) aff shall adopt and d rules to carry out These bylaws t be limited to, that the the final mented along with medical record	S087	22	The Medical Executive Committee was presented the survey report and instructed	e	DATE 08/16/2011	
		nin 30 days for 2 of 5 medical			the importance of enforcing the Medical Staff bylaws by the hospital's legal counsel. The Board of Directors issued a	he		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CON	NSTRUCTION	(X3) DATE S				
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED		
		150164	B. WIN			07/11/20	011		
		II.	J. 1711		ODRESS, CITY, STATE, ZIP CODE	l			
NAME OF F	PROVIDER OR SUPPLIER	t .		4011 S MONROE MEDICAL PARK BLVC					
MONRO	E HOSPITAL			BLOOMINGTON, IN47403					
				<u> </u>					
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	·		DATE		
TAG	Findings include: 1. Review of patient indicated the follow MR#2 was admitted and the record lacked progress note. MR#4 was admitted 4-23-11 and the record summary or final progress note. MR#4 was admitted 4-23-11 and the record summary or final progress note. MR#4 was admitted 4-23-11 and the record summary or final progress note. F. A discharge sum dictated on patient house patients who reprive the progress of the discharge summary of final substituted for the discharge and their medical record patient's discharge. Incomplete records result in the record physician will be auprivileges, including consults, etc. 3. Interview with # confirms the medical lack discharge summary confirms #P4 is deligned by the progress of	at medical records on 7-11-11 ring: It on 5-8-11, discharged 5-10-11 ring and a discharge summary or final It on 4-22-11, discharged rod lacked a discharge rogress note. Redical staff Rules and red 8-2009, indicates the mary shall be written or rospitalizations over forty-eight progress note may be lischarge summary only for required less than a 48-hour ration. Re responsible for completing les within thirty (30) days of a Failure to complete by the suspension date will becoming delinquent and the retomatically suspended of all red admitting, emergency room, S3 on 7-11-11 at 1255 hours real records of MR#2 and MR#4 maries or final progress notes; rinquent and has not been real staff rules and regulation S5 on 7-11-11 at 1315 hours real records of MR#2 and MR#4 maries or final progress notes. S4 on 7-11-11 at 1405 hours rinquent on completing medical		TAG	message to the Medical Stafthe August meeting on the enforcement of bylaws relate medical record completion at proper medical record documentation. The Medical liason office will monitor enforcement of violations of the bylaws and medical staff rule and regulations - reporting all instances to the CEO daily. Performance Improvement of report has been developed related to the medical staff at performance of their duties.	f at ad to and Staff the es I	DATE		
		been suspended per the							
	medical staff rules a	and regulation requirements.							
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	L F6RI11	Facility II	D: 004287 If continuation sl	heet Pac	l ge 6 of 7		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150164	(X2) MULTIPLE CC A. BUILDING B. WING	00 	COMP 07/11/2	LETED
NAME OF PROVIDER OR SUPPLIER MONROE HOSPITAL			4011 S	ADDRESS, CITY, STATE, ZIP COD MONROE MEDICAL PARI MINGTON, IN47403		
	SUMMARY S (EACH DEFICIEN	STATEMENT OF DEFICIENCIES SICY MUST BE PERCEDED BY FULL SELSC IDENTIFYING INFORMATION)			CTION ILD BE	(X5) COMPLETION DATE